UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
DIVISION OF JUDGES

COMMUNITY EMERGENCY MEDICAL SERVICES, INC.

and Case 7–CA–45193

INTERNATIONAL ASSOCIATION OF EMTS and PARAMEDICS, NAGE–SEIU, AFL–CIO.

Rana S. Roumayah and Donna M. Nixon, Esqs., for the General Counsel.
Paul W. Coughenour, Esq. (Brady, Hathaway, Brady & Bretz, PC.), of Detroit, Michigan, for the Respondent.

DECISION

STATEMENT OF THE CASE

JOHN T. CLARK, Administrative Law Judge. This case was tried in Detroit, Michigan, on June 29–30 and October 17, 2005. The charge was filed June 10, 2002, by the International Association of EMTs and Paramedics, NAGE–SEIU, AFL–CIO, (the Union) and the complaint was issued March 28, 2005. The complaint alleges that Community Emergency Medical Services, Inc., (the Respondent) violated Section 8(a)(1) of the National Labor Relations Act (the Act) by threatening employee Vickie Pavloff, in late January or early February 2002,[1] because she engaged in protected concerted activities, and Section 8(a)(1) and (3) of the Act by discharging employee Pavloff on June 5, 2002, because she engaged in protected concerted activities. The Respondent denies any unlawful conduct.

On the entire record, including my observation of the demeanor of the witnesses, my credibility determinations based on the weight of the respective evidence, established or admitted facts, inherent probabilities, and reasonable inferences drawn from the record as a whole and, after considering the briefs filed by the parties, I make the following

FINDINGS OF FACT

I. JURISDICTION

The Respondent, a corporation, with offices and facilities in Southfield, Michigan, and at other locations in southeastern Michigan, is engaged in providing emergency and nonemergency medical treatment and transportation services to the public. During the year 2004, a representative period, the Respondent, in conducting its operations described above,

[1] All dates are in 2002 unless otherwise indicated.

derived gross revenues in excess of $500,000 and purchased and received at its Michigan facilities goods and supplies valued in excess of $50,000 directly from points outside the State of Michigan. The Respondent admits and I find, that it is an employer engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act. I also find that the Union is a labor organization within the meaning of Section 2(5) of the Act.

II. ALLEGED UNFAIR LABOR PRACTICES

A. Introduction

The Respondent provides emergency and nonemergency treatment and transportation to health care organizations, municipalities and the public. The Respondent dispatches emergency vehicles for 911 emergency calls and nonemergency calls from several stations in southeast Michigan, including Oakland and Wayne Counties. Typically, a telephone call is received by the dispatcher, who when determines the priority of the "run." A Priority 1 dispatch involves a person so critically ill that a delay in care will threaten life and the responding crew may drive with flashing lights and siren operating (R. Exh. 25 at 2, 44).

An EMS crew is two paramedics. A paramedic is the highest trained prehospital emergency care provider in the EMS system. Paramedics are assigned as a crew for the shift and mutually determine who drives the vehicle and who attends to the patient. The attending paramedic is the individual who is in charge of, and responsible for, the care and transport of the patient and the completion of the Oakland County EMS Medical Report (the run sheet) and Oakland County EMS Refusal of Care/Transport form (the sign and release form) (GC Exh. 26).

In addition to following the Respondent's rules and regulations the EMS crew is required to comply with medical protocols issued by the county in which they work. The Oakland County Medical Control Authority has a Medical Treatment Protocol entitled "Refusal of Care/Transportation Policy" (R. Exh. 24). This policy specifies what action EMS personnel must take if a patient refuses emergency care or transportation to the hospital. In order to refuse the patient must appear to be competent. The protocol defines a competent individual as one who is awake, alert, oriented, and does not have an illness/injury which may interfere with mental functioning and appears to be capable of understanding the circumstances of the situation. If the patient is competent to refuse, EMS personnel must clearly explain the nature of the illness/injury, the indications for emergency care or transport, and the possible complications that could arise without proper care or transport.

If the patient still refuses transport, the individual is asked to sign a statement to that effect contained on the "Oakland County EMS Refusal of Care/Transportation Form" (GC Exh. 2). If the individual refuses to sign, the EMS personnel are instructed to document and witness that fact. EMS personnel are further directed to record the patient assessment and any discussion, taking care to note the mental status of the patient. The protocol then directs that the EMS Refusal of Care/Transportation Form be filed in accordance with the agency's internal protocol. It is the Respondent's written policy that all paperwork be completed immediately after the conclusion of the call (R. Exh. 20, Community EMS Policy, Subject: Crew Responsibilities/Attendant Responsibilities, March 1988). Testimony establishes, however, that if the crew is assigned back-to-calls the paperwork may be completed as soon as possible, but in no case later than the end of the shift.

Of special significance is a section of the protocol that is printed in bold type and encompassed by a bold border. This section dictates that medical control must be contacted in all cases were medical care was provided, were EMS personnel believe that the refusal of care

or transport might compromise the patient's health, or the patient meets the requirements of 1-3 on the Refusal of Care/Transportation Form. Items 1-3 on the Refusal of Care/Transportation Form are questions relating to the patient's (1) orientation, (2) immediate recall, and (3) other considerations. Directly beneath the questions, is the statement, in bold type, that "**If the answer is False to any of the above questions, the patient's competency is in question and Medical Control <u>MUST</u> be contacted.**" (Emphasis in the original.) Medical Control is usually the emergency room physician at the hospital were the patient would be transported (Tr. 25–28).

If a paramedic leaves a patient without a signed release or the Refusal Declination witnessed (the reverse side of the sign and release form, GC Exh. 26) the paramedic may be deemed to have abandoned the patient. Abandonment is defined as "the unilateral termination of care . . . without the patient's consent and without making provision for continuing care by a medical professional with skills at the same or a higher level" (R. Exh. 42 at 53).

B. The Respondent's Knowledge of Pavloff's Union Activity

Vickie Pavloff was employed as a paramedic by the Respondent from May 1997 until her discharge, on June 5, 2002. During the spring of 2000 Pavloff signed a union authorization card. In October 2000, Pavloff contacted the Union in an attempt to rekindle the organizing campaign, as a result Pavloff became the lead union organizer. Her activities consisted of soliciting a majority of the authorization cards, distributing and posting union literature, distributing union paraphernalia, and speaking on behalf of the union with employees. She was the union observer at the January 2001 representation election. Although the Union lost the election Pavloff continued her organizing efforts and the Union won a January 2002 election. Supervisors Troy Rowe and Jeff Dilworth testified that they knew of her union activities.

C. The 8(a)(1) Threat and Other Animus

Pavloff testified that sometime shortly after the January 2002 election Supervisor Dilworth called her while she was working at the Respondent's Walled Lake station. After she answered he told her that he wanted to switch to an untapped line. When he came back on the phone he said, "I just wanted to call you and give you a heads up. They're pulling all of your paperwork, looking for any and everything to get you on." She replied "Well, they haven't found anything yet, have they? He said "No, and it's pissing them off." In response to a question about anything else that was said during the call Pavloff answered "We discussed our kids. I don't remember. We talked about a couple of different things, but that one, in particular, is—I did ask him why, you know, he was calling, and he just basically said, 'I just thought you needed to know.'" (Tr. 38.) Dilworth denies that the conversation occurred.

On April 12, 2002, approximately 12 employees, some carrying signs, walked up and down the sidewalk in front of the Respondent's Southfield station. Pavloff, who helped organize this action, carried a large sign with "Women harassed here" written on it. A newspaper photo shows Pavloff, and others, being sprayed by water from a lawn sprinkler system. (GC Exh. 3.)

On April 19, Ken Slinker, the Respondent's acting chief operations officer, wrote a letter to Pavloff. Slinker explained the Respondent's policy against harassment of employees in any form, and requested that Pavloff provide the Respondent with the facts on which she based her conclusion that women were harassed by the Respondent. After noting the newspaper article and stating that the allegations were very serious and that they defame and injure the

Respondent's reputation, Slinker ended the letter by stating that "[f]ailure to substitute facts to support these allegations may result in CEMS taking legal action to protect its reputation and will be considered libel and slander." (GC Exh. 4.)

Pavloff also testified that during this same time period Supervisor Jim Buell approached her while she was working at Station One. He told her that he would not take any part in the retributions involving picketing. After Pavloff replied that "it's already started" Buell said "I just want you to know I will not take part in it."

Counsel for the General Counsel further offers General Counsel Exhibit 21 as additional evidence of the Respondent's animus. General Counsel Exhibit 21 is a laminated poster over 2-½ feet long and 1-½ feet wide. The heading, set in inch high red letters, is "Are the Actions the Union is Taking In Your Best Interest? Are They Being Truthful With You?" At the bottom, in the same lettering, is "Make Sure You Have the Facts!" In the center of the poster, just beneath the heading is "Michigan Employment Security Position." Directly beneath that title, in a box outlined in red, is a copy of the Michigan Employment Security Board of Review decision reversing a referee's decision and finding that Pavloff was discharged for cause. Beneath and to the left, is another box also outlined in red, entitled "IAEP Proposed Position*" the asterisk refers to the following sentence at the bottom of the poster "*Unsigned proposed "settlement" of IAEP's ULP's." The body of the "settlement" contains the following statements highlighted in red, "WE WILL NOT fail and refuse to bargain with Vickie Pavloff as the agent of your Union." And below that "WE WILL bargain with Vickie Pavloff as the agent of your Union." Across from the notice, but on the same level, is a box, outlined in red, captioned "CEMS Position." This box contains a letter dated March 19, 2003, and signed "Greg Beauchemin," President & CEO. The letter states that the Union continues to file multiple unfair labor practice charges against the Respondent some of which pertain to employees who have be terminated for substandard patient care. The letter directs the reader to the Michigan Employment Security Board of Review decision. The letter next refers to the box containing the notice and refers to it as "a copy of a proposed settlement prepared by the NLRB that, in essence, would force us to recognize the individual mentioned above [Pavloff] as a bargaining representative." The letter continues:

> As a result of the union's strategies, we are going to a NLRB hearing forcing us away from the positive momentum we have recognized with the Federal Mediation and Reconciliation [sic] Service. This hearing will most likely cause a delay benefiting neither the company nor you as an employee.
>
> . . . .
>
> During the next few months, the union may ask you to do things to support their position and send management a message. I ask you . . . not to participate in activities that may endanger our patients.

Emanating from each side of the center box entitled "Michigan Employment Security Position" is a solid line ending with an arrow pointing to the corresponding lower box.

D. The Discharge

On May 12, 2002, Novicki, with Pavloff as the attending paramedic, received a Priority One—lights and siren—dispatch to the Farmington Health Care Center (the Care Center). The Care Center is an extended care, skilled nursing facility. The dispatch was to transport a patient

suffering from bradycardia (a slow heart rate), to a hospital. The patient involved herein, for reasons of confidentiality, will be refereed to only as "Joe."

The Respondent's dispatch records show that the crew arrived on the scene at approximately 9:45 p.m., about 9 minutes after the dispatch. As Pavloff approached the patient she saw Registered Nurse Annette Skelly, the weekend nursing supervisor, attempting to start an intravenous line on the patient's arm. Skelly testified that it was standard protocol to administer fluids in an attempt to raise the patient's blood pressure while waiting for the arrival of the EMS crew. Licensed Practical Nurse Susan Schotten testified that she was the nurse assigned to care for the patient on May 12 and that she had been his nurse for a number of months. It was she who took his low blood pressure readings and had asked Skelly, her supervisor, to verify the readings, which she did. Schotten then relayed the information to the patient's Physician Assistant (P.A.) Jeff Douglas. Douglas consider the low readings as well as other facts concerning the patient's condition and ordered Schotten to request an ambulance for emergency transport to the hospital. Schotten requested the ambulance. She had done this on previous occasions, for the same condition, during the months that Joe had been under her care. The demeanor of Skelly and Schotten was that of totally credible and unbiased witnesses who made their very best effort to recount the events in a truthful manner. I fully credit their testimony in general and specifically where it conflicts with the testimony of Pavloff and Novicki.

Although Joe had a tracheotomy tube inserted, he could whisper, read and write. Before making a physical assessment the EMT must obtain the patient's permission, assuming the patient is alert and has the mental capacity to grant permission. In that regard Pavloff asked Joe a series of questions such as, who he was, who the nurses were, where he was, and the day of the week. When answering the question "what day of the week was it," Joe answered "Monday? Is it Monday?" Pavloff replied "close. It's still Sunday," and Joe responded, "Oh, Mother's Day," and asked if she was a mother.

Having determined that Joe was alert and oriented, Pavloff performed a "head-to-toe" assessment. While she was performing the assessment, Novicki placed the patient on a heart monitor, checked his blood pressure and pulse rate, and observed his respiration, all of which appeared normal. Pavloff' arrived at the same conclusion, finding that the patient's only compliant was of a headache, which he indicated was because of the rain. Schotten was with other patients and was not present when Pavloff and Novicki were with Joe. Skelly testified that she was in and out of the area surrounding the patient and that she observed that Novicki was getting a much stronger blood pressure reading than the one she had gotten just before the ambulance was requested. She told the crew of her previous finding, and gave Pavloff the patient's chart. Pavloff noted that the patient had a history of anemia, stoke with left–side paralysis, and congestive heart failure. Pavloff asked for the results of a previous blood test, but the results were unavailable. Skelly told Pavloff that P.A. Davis was concerned that the patient might have internal bleeding.

Pavloff, having decided that the patient was competent, asked him if he wanted to go to the hospital. He replied in the negative. Skelly then stated, in the patient's presence, that his doctor wanted him to go to the hospital. Pavloff told the patient that his doctor was concerned about possible internal bleeding. The patient asked Pavloff if he was "okay now." Pavloff said "yes." She explained at the hearing: "I can't tell him, 'No, you're not.' I didn't have anything else to prove it. I asked for his blood work, they didn't have it. I had nothing else to go on but what I could see, feel and hear." Skelly, sensing that the crew was not going to transport the patient went to find Schotten. Before locating Schotten, Skelly observed Pavloff and Novicki walking toward the exit. Pavloff was talking on her cell phone and said "Oh they sent me on a wild

goose chase" (R. Exh. 32 at 1). Pavloff admits committing "an error in judgment" when she did not ask the patient to sign a "Sign and Release" form.

The Respondent's records indicate that Pavloff "cleared" the scene, meaning that she and Novicki had left the location and were available to respond to a call, at approximately 9:04 p.m., almost 19 minutes after arriving. The dispatcher told her when she called to clear to return to her station because the crew was needed as backup. On arriving at the station Pavloff dumped "all my stuff" on the table. In addition to her notes from the run "her stuff" included personal bills that she planned on paying. She said that before she could begin working on anything the crew was sent on a run. Almost immediately on returning they were dispatched again, before being summoned to Station One, the Southfield headquarters, by Troy Rowe, an operations supervisor for the Respondent.

Rowe testified that he was the shift operations supervisor on May 12, 2002. During the shift he was told by a dispatcher to call Nursing Supervisor Skelly at Farmington Health Care Center regarding sending another crew to transport a patient because the first ambulance crew had refused. Rowe contacted Skelly who complained that Pavloff and Novicki did only a minimal patient survey and that Pavloff told the patient "you don't want to go to the hospital do you." After talking with Skelly, Rowe drove to Botsford Hospital where the second crew had transported the patient. At the hospital Rowe observed the patient and noted that the emergency room report also contained a low blood pressure reading. While at the emergency room Rowe called Ken Slinker, the Respondent's vice president of operations. Slinker arrived and Rowe advised him that there was a potentially serious situation.

After talking with Slinker, Rowe contacted Pavloff and Novicki and told them to meet him at Station One with the paperwork from the Farmington Health Care Center run. At Station One Pavloff told him that she had not yet written the run sheet. Rowe ordered her to complete the run sheet and write an incident report. When Rowe read the run sheet he noticed that Pavloff had written, several times, that the patient was "vent dependent." Being on a ventilator is "not even close" (Tr. 447) to an oxygen hook up. Reporting that a patient is on a vent when they are not "is a pretty basic mistake" as confirmed by Novicki (Tr. 228). Rowe knew from seeing the patient, and his conversation with Skelly, that the patient was not vent dependent. Based on this glaring error, as well as Skelly's complaint, Rowe concluded that a thorough initial patient assessment had not been performed.

Over the next 2 weeks Rowe conducted a full investigation that included interviews with Pavloff and Novicki. Based on his investigation he concluded that Pavloff, as the attending paramedic, failed to complete the run sheet in a timely manner, failed to properly determine if the patient was competent to refuse treatment, failed to do a thorough initial assessment of the patient, failed to obtain the sign and release form, and failed to contact medical control. Furthermore, Rowe concluded that by leaving the patient without obtaining his written consent, without ensuring that he fully understood the potential risks to his decision and "without making provision for continuing care by a medical professional with skills at the same or a higher level," Pavloff had committed patient abandonment. (R. Exh. 42.) Based on the foregoing Pavloff was discharged on June 5, 2002 (GC Exh. 7), and Novicki received a 1-day suspension and a last-chance letter (GC Exh. 9).

III ANALYSIS and DISCUSSION

In *Wright Line,* 251 NLRB 1083, (1089), enfd. 662 F.2d 899 (1st Cir. 1981), cert. denied 455 U.S. 989 (1982), the Board established an analytical framework for deciding cases turning on employer motivation. To prove that an employee was discharged based on an unlawful

motive, the General Counsel must first persuade, by a preponderance of the evidence, that an employee's protected conduct was a motivating factor in the employer's decision. If the General Counsel makes such a showing, the burden of persuasion shifts "to the employer to demonstrate that the same action would have taken place even in the absence of the protected conduct." *Wright Line,* supra, 251 NLRB at 1089. See also *Manno Electric, Inc.,* 321 NLRB 278, 280 fn. 12 (1996). The elements the Board considers when determining whether an employer's conduct was discriminatorily motivated are generally the alleged discriminatee's protected activity, employer knowledge of that activity, and union animus. *Farmer Bros. Co.,* 303 NLRB 638, 649 (1991), enfd. mem. 988 F.2d 120 (9th Cir. 1993).

Under the standards stated above, I conclude that counsel for the General Counsel has met her burden of establishing by a preponderance of the evidence that Pavloff's union and protected activities was a factor in the Respondent's decision to discharge Pavloff. Thus, as set forth above, there is abundant unrefuted evidence that Pavloff engaged in union activities and that the Respondent was aware of those activities. Supervisors Rowe and Dilworth admitted knowledge of her union activities. The evidence also demonstrates that Ken Slinker the Respondent's operations officer was aware of her concerted activities, and exhibited animus towards those actives. It was he who sent Pavloff a letter threatening her with legal action for protesting, along with other employees, harassment of women in the workplace. Evidence of union animus is provided by the letter that was sent to employees and posted on General Counsel's Exhibit 21. The letter states that as a result of the Union's strategies the Respondent is going to a NLRB hearing, thereby forcing it away from "positive momentum" and that the hearing will most likely cause a delay benefiting neither the Respondent nor the employees. The letter also suggests that the Union may ask the employees to "do things that may endanger our patients."

The Respondent presented no evidence to refute Pavloff's testimony that Mark Millbreath deliberately directed the lawn sprinkler heads towards the marchers before turning them on. Nor did the Respondent refute Pavloff's testimony that Millbreath engaged in other acts of harassment during the protest. The Respondent offered no evidence in contradiction of Pavloff's testimony that Supervisor Buell told her, shortly after the picketing, "that he would not take any part in the retributions involving last week's picket." The Respondent in its brief, notes that Buell is not employed by the Respondent, and was not subpoenaed to testify by the General Counsel. To the extent that the Respondent is implying that Buell's absence indicates that his testimony would contradict Pavloff, I reject that implication. Having a witness corroborate undisputed testimony is cumulative and of no probative value. Thus, Pavloff testimony remains uncontradicted and I am without reason for disbelief That is not, however the case regarding the alleged threat made by Dilworth.

The only 8(a)(1) allegation contained in the complaint is based on a telephone conversation Pavloff claims occurred between her and Operations Supervisor Jeff Dilworth. Although Pavloff did not remember the date she claimed that it happened shortly after the Union won the second representation election. Dilworth allegedly called from Station One, to the Walled Lake Station where Pavloff was working.

Immediately after Pavloff answered, Dilworth said "Let me switch to an untapped line." When he came back on the phone he said "I just wanted to call you and give you a heads up. They're pulling all of your paperwork, looking for any and everything to get you on." When Pavloff asked if they had found anything he said "no and it's pissing them off." When asked what else was discussed she said "our kids. I don't remember. We talked about a couple of different things, but that one, in particular, is—I did ask him why, you know, he was calling, and he just basically said "I just thought you needed to know." (Tr. 38.)

Dilworth denied that the conversation occurred. He further denied that neither, he nor anyone else, had ever reviewed Pavloff's files looking for evidence of misconduct. Confronted by this conflicting testimony, I have carefully considered the demeanor of the witnesses and the plausibility and consistency of the testimony. I find Dilworth's testimonial demeanor to be that of a truthful witness, who testified without doubt or hesitation. I credit his denial over Pavloff's testimony. In addition to her demeanor, I find Pavloff's testimony regarding this conversation implausible, and inconsistent with later undisputed events. The primary question—one which Pavloff acknowledged—is why Dilworth put his job at risk by warning Pavloff. At the end of her testimony about this conversation, almost as an afterthought, Pavloff said that she asked that question and Dilworth allegedly said "I just thought you needed to know." Not only is that answer obvious, redundant, and a classic understatement, it does nothing to explain why he would risk discharge to warn Pavloff. The mention of children might indicate some connection beyond work, but no factual predicate was established. Indeed, if there was a relationship outside of work, and even if not, it would most certainly have behooved Dilworth to call Pavloff at home. Dilworth must have known that any taped conversation that begins with the caller saying that he is switching to an untapped line, is bound to arouse suspicion.

Pavloff's later conduct is also inconsistent with that of an employee who has been warned that her reports were being reviewed in order to provide a reason for her discharge. She admits that she did not even attempt to obtain a sign and release form from the patient. She did not complete her run sheet immediately after the call. When she did fill out the run sheet it contained errors. In an attempt to explain why she did not have paperwork with her to give to Rowe, she admits that she "inadvertently" left her clipboard—that contained all her necessary paperwork—back at the station, and as a result had to "scrounge up paperwork out of our truck." Based on the foregoing I find that Pavloff's conduct with regard to the paperwork requirements of the attending crew member is inconsistent with her testimony that she was warned that the Respondent was perusing her reports in an attempt to find a reason for her discharge. Thus, in addition to Pavloff's poor testimonial demeanor, when testifying about this incident I find her testimony implausible and inconsistent.

Accordingly, I find that the Respondent did not violate Section 8(a)(1) of the Act, as alleged and I shall recommend the dismissal of that allegation of the complaint.

Having found that counsel for the General Counsel has met her initial burden, the burden of persuasion shifts to the employer to demonstrate that it would have taken the same action even in the absence of the protected activity. The employer cannot simply present a legitimate reason for its actions but must persuade by a preponderance of the evidence that the same action would have taken place even in the absence of the protected conduct. *Key Food,* 336 NLRB 111, 112 (citations omitted) (2001). As set forth in detail below I find that the Respondent has successfully rebutted the General Counsel's initial case and has proved, overwhelmingly, that it would have terminated Pavloff pursuant to its well established policies and protocols even in the absence of her union affiliation or concerted actives.

A. The Respondent's Defense

One of several reasons that the Respondent contends that it discharged Pavloff is her failure to even ask the patient to sign a "sign and release" form. In essence, asking the patient to sign the form is asking the patient to document that the patient understands the nature of the illness/injury, the indications for emergency care or transport, the possible complications that could arise without proper care or transport, and asking the patient to acknowledge responsibility for his decision and his release of the Respondent from liability.

Assuming, for the moment, that Pavloff's contention that the patient was competent to refuse transport is correct, she was still required to ask the patient for his signature on the sign and release form. Pavloff acknowledged this requirement, for the first time, during the hearing. She still refuses to acknowledge the severity of her omission, categorizing her failure as a technicality which was caused by "an error in judgment" (Tr. 108, 60).

The Respondent's expert witness, Dr. Timothy Vayder, testified unequivocally that the Oakland County EMS Refusal of Care/Transport form (the sign and release form) was part of a protocol, and that a protocol is a hard and fast rule that absolutely must be followed by all paramedics (Tr. 571–572). Dr. Vayder was extremely well qualified to offer his expert opinion. He position was that of acting assistant director for medical control. The job duties of that position entail producing, writing, and enforcing protocols. Dr. Vayder is also a certified emergency room physician and, before becoming a physician, was a field and supervisory EMT.

Thus, it is obvious that compliance, not judgment, was required of Pavloff. Her unexplained failure was no mere technicality. It is a glaring omission that is evidence of gross incompetence in the performance of a simple, but critical, function of her position as the attending paramedic. Her failure exposed the Respondent to the risk of a potentially significant liability. Her failure cannot be attributed to a momentary mental lapse. Pavloff admits thinking that she needed a signed release as she was leaving the Care Center. In addition to finding her conduct inexplicable, I also find that her refusal to acknowledge the obvious potential impact of her omission, under the circumstances, reflects adversely on her credibility.

Pavloff also denies that she was required to contact medical control notwithstanding the undisputed fact that the patient incorrectly identified the current day. Pavloff testified that the patient had to be competent in order for him to allow her to physically examine him. Competency is also necessary for a patient to knowingly refuse care or transportation. Pavloff contends that after the patient incorrectly identified the day as Monday, she replied "close. It's still Sunday," and he then responded that it was Mother's Day. She also testified that "I asked him enough questions to get a real good idea that he knew where he was, who he was, and why we were there." Counsel for the General Counsel submits in brief that the patient answered all of the questions appropriately, and "[i]n addition, the patient told Pavloff that it was Mother's Day" (GC Br. at 24). Regardless of the appropriateness of the answer, the record is clear, and I find, that Pavloff asked the patient only once what day it was, and his answer was incorrect (Tr. 53–54, 109–111).

Accordingly, the patient gave a false answer to a question contained on the Oakland County EMS Refusal of Care/Transport form. It is clearly printed on the form—in bold print—that any false answer puts the patient's competency in question and requires that the EMT contact Medical Control. The Oakland County Medical Control Protocol entitled "Refusal of Care/Transportation Policy" also declares—in bold print—that that medical control must be contacted if "the patient meets the requirements of 1–3 on the Refusal of Care/Transportation Form" (R. Exh. 24). Item I B, on the Refusal of Care/Transport Form (GC Exh. 2) is "Patient knows current day, date, and/or year?" It is obvious that the "close" answer that satisfied Pavloff, is still false. Once again Pavloff applied her judgment rather than follow the explicit requirement of the protocol. Moreover, the fact that other medical personnel found the patient alert and orientated is also of no relevance in regards to the protocol. The protocol does not require that a patient who gives a false answer be found incompetent, it only directs the EMT to contact medical control and that is precisely what Pavloff failed to do.

Dr. Vayder opined that a person with low blood pressure might lack sufficient pressure to supply blood to the brain and that "could certainly cloud one's judgment" even if they are alert and oriented. (Tr. 558, 615–616.) LPN testimony was even more significant. She credibly testified that because of the patient's falling blood pressure he was lethargic—"out of it"—agreeing with everybody (Tr. 393). Thus, she testified that the patient would agree with the person who was talking to him. As an example Schotten testified that the patient had agreed with her that it was necessary to go to the hospital before the crew arrived, and he agreed again, after the second crew came on the scene. (Tr.392–394). Schotten was the patient's nurse on May 12 and had been for months. She had observed this condition on prior occasions when he had been transported to a hospital because of low blood pressure. Nurse Skelly also observed the same lethargic condition on May 12 (Tr. 362). Had Pavloff contacted medical control as required, perhaps she would have been directed to consult with the nursing staff who had been caring for the patient for the months.

Pavloff's failure to contact medical control on her own volition is disconcerting. She testified that a function of medical control is dispute resolution. Pavloff claims, based on her patient assessment, that the patient did not need to be transported to the hospital. Yet she denies the existence of any dispute, notwithstanding that the nursing staff had recommended to the patient's Physician Assistant that the patient be transported to the hospital and he ordered the transport. Even absent a process for dispute resolution, commonsense dictates that some attempt should have been made by Pavloff to reconcile the diametrically opposed findings and conclusion.

Pavloff's testimony regarding the patient's possible internal bleeding also appears to be inconsistent. She acknowledges that she knew that the Physician Assistant was concerned about the possibility of the patient having life threatening internal bleeding. Despite her evasive answers, it is clear that she agrees that the possibility of internal bleeding can only be completely excluded based on test results, and not by the external exam given by the EMT during the patient assessment. Those facts notwithstanding, Pavloff continues to argue that transport was unnecessary based solely on her external examination (Tr. 85–87).

Pavloff was more candid, in a round about way, when she admitted that she did not believe that the blood pressure readings, and other vital signs taken by the nursing staff, were accurate. She maintains that "[n]ursing homes are notoriously known for doing poor vitals," and that had their findings matched hers, or had she believed their findings, she would have "begged" the patient to go to the hospital (Tr. 117–119). Whenever Pavloff testified about the nursing staff her disdain was palpable. Perhaps her attitude was a factor in her failing to recognize the patient's serious, if not critical condition. Perhaps her ego prevented her from calling Medical Control to resolve the conflicting medical findings, and the fact that the patient's Physician Assistant had ordered him transported to the hospital. Or perhaps there is another reason. Regardless, Pavloff placed herself in the midst of a conundrum of her own making when she inexplicably failed to ask the patient to sign a release.

The evidence establishes that Pavloff committed patient abandonment under any of the definitions used by Rowe, as well as Dr. Vayder's testimony, all of which were similar. Counsel for the General Counsel does not seriously dispute the underlying facts but argues that the discharge of Pavloff was a pretext because if it was truly patient abandonment the Respondent would have followed its past practice of discharging both crew members.

I find that Pavloff committed patient abandonment when she left the patient without obtaining his consent and without making any provisions for his continuing care by a medical professional with skills at the same or higher level as herself.

Pavloff testified that she called the dispatcher as she was leaving the Care Center and announced that she and Novicki were clear. The Respondent's policy is that the run sheet is to be completed as soon as the run is over. Rowe credibly testified, on cross examination, that the Respondent does not consider that a run is over until the run sheet is prepared, and that a crew is not required to call dispatch and "clear" until the run sheet is completed. This testimony was not contradicted. Pavloff offered no explanation why she chose to call the dispatcher and clear as she walked out the door rather than write the run sheet while she was in the Care Center. She passed a desk on her way out and in any case she had a clipboard. She explained that she was unable to write in the emergency vehicle because "there's not enough quality lighting in the truck for me to see to write in the dark and in motion at the same time (Tr. 67)." I am willing to accept that writing in a moving vehicle is difficult. But I find unbelievable her statement that the interior lighting of an emergency vehicle, in either the cab or the transport area, is insufficient to write a 20 minute report. Accordingly, I find that Pavloff has offered no satisfactory explanation why she did not complete the run sheet while still at the Care Center or in the vehicle before calling the dispatcher and before driving away. Once again, another inexplicable omission by Pavloff.

Initially Pavloff testified that after returning to the station she and Novicki were called out twice more (Tr. 61). Later she stated that there "just wasn't enough time" between runs to complete the run sheet (Tr. 67). When asked to approximate the amount of time it took her to complete the run sheet she refused, claiming a lack of knowledge (Tr. 140–141). Rowe, who observed her as she wrote the run sheet, estimated that it took approximately 20 minutes (Tr. 438). The Respondent's dispatch records indicate that Unit 778 (Pavloff and Novicki) cleared the Care Center and were "available" at 21:04:35 or approximately 9: 04 p.m. (R. Exh. 11). Pavloff estimated that the Care Center was 20 minutes from station (Tr. 142). Using round numbers, if the crew arrived at the station at 9:30 p.m., Pavloff had 30 minutes, until their next run at 22:00:27 or 10 p.m., to write a 20 minute report. Accordingly, I find that Pavloff did not provide a credible excuse for not completing the run sheet before she left the Care Center or before beginning the next run.

Furthermore when the run sheet was finally given to Rowe it erroneously reported, in several places, that the patient was vent-dependent—a major mistake. Pavloff also marked the box at the bottom of the report indicating that the paramedic accompanied the patient to the hospital. A mistake for which no explanation was offered and which appears to be inexplicable.

Although I have found Rowe to be a more reliable and credible witness than Pavloff I am not convinced that Pavloff lied to him by claiming that her run sheet was at the station. This incident occurred after Rowe ordered Pavloff and Novicki to meet him at the main station. He asked them for their paperwork for the day and he claims that Pavloff initially told him that the run report and the sign and release form were at their station. Rowe claims that he then told her he had checked the station and the paperwork was not there, at which time Pavloff changed her story and said that the run sheet had not been written.

Both Pavloff and Novicki testified that Pavloff told Rowe that it was her notes that were back at the station, not the completed run sheet. Although I credit Rowe's testimony that he did not yell and scream at Pavloff, I also believe Novicki's testimony that the conversation between Rowe and Pavloff was heated. It is believable that Rowe was upset. He had only just discovered that a patient had been refused transport by one of his crews that could possibly place the patient at increased risk, a result that could cause the Respondent to incur a significant financial liability. At the very least he knew that his boss was aware of what happened. And he had first hand knowledge that Nurse Skelly was an extremely irate. Both

nurses at the Care Center were very upset by the crew's failure to transport the patient—something that they had never experienced. All of this may have contributed to Rowe misunderstanding exactly what was said by Pavloff. This finding in no way diminishes any of the previous findings, set forth above, that overwhelming support the Respondent's position.

The Respondent also submitted evidence of consistent disciplinary treatment of paramedics who were deemed to have abandoned a patient. Theresa Reading, who was the Respondent's operations supervisor in 1996, creditably testified, without contradiction, that she discharged a two-person crew for patient abandonment when they both left a patient alone in the ambulance. She also testified that it was her understanding that two other employees had previously been discharged for patient abandonment, although she did not testify as to the circumstances. The Respondent entered documentary evidence that a paramedic was discharged for abandoning a psychiatric patient in hospital waiting room. In another case, that was the subject of an unfair labor practice hearing, the paramedic left the patient in her home and went to sleep in the ambulance. Notwithstanding the fact that that his partner eventually obtained a release form, the paramedic was still discharged for patient abandonment. After a hearing an administrative law judge dismissed the unfair labor practice complaint. The Respondent also represents that no exception to the dismissal was taken by the General Counsel.

B. The General Counsel's Rebuttal Evidence

Counsel for the General Counsel, in an attempt to rebut the Respondent's now-shifted burden, contends that the following incidents are evidence of disparate treatment because the employees committed similar offenses but were only suspended.

Counsel for the General Counsel initially points to the fact that Pavloff's partner was issued a 1-day suspension along with a last-chance letter. Counsel for the General Counsel, however, correctly recognizes that it is the attending paramedic that is responsible for completing the paperwork (Tr. 78–79, 121–123), which includes both the run sheet and, even more importantly from a liability prospective, the sign and release form. In this case there is no question as to who was in charge of the run, who made all the decisions, and who bears the responsibility for the outcome.

Such was not the case when two employees each received a 1-day suspension for failing to complete paperwork or contact medical control for a run that was made on February 14, 2002. Both were Basic EMT's, which means that they held a lower licensure than Pavloff, and had less training. It is unclear from the facts presented by the counsel for the General Counsel which, if either of them, was the attending paramedic. Tara Pina's written warning (GC Exh. 11), is for failing to complete paperwork or contact medical control, it is the only written warning concerning this incident in the record. The other employee, Shaina Shevin, testified that her warning was identical or similar. Pina initially testified that she was the attending. After being shown the Incident Report (GC Exh. 12), where she is listed as the driver, she said that she did not realize that she was not the attending. Shevin, who wrote the incident report, is listed as the attendant. She said that she could not recall who was the attending but stated " I don't know that most people pay attention to driver versus attendant on the IRs" (Tr. 692). The incident report consistently refers to "the crew." Both witnesses used "we" when testifying even when responding to questions that were asked in the singular. (See i.e., Tr. 636–637). Shevin testified that she and Pina were equally responsible for the call (Tr. 702).

When this crew arrived at the nursing home the patient's mother, who was also his legal guardian, was at his bedside. The mother and the son both refused transport to the hospital.

The crew took the patient's vital signs, which were normal. They relayed his vitals signs to his treating physician's office. They were told that the patient's condition was chronic and that "it was perfectly safe to wait until the next day." They offered to transport the patient to the hospital. The patient, his mother, and the treating physician's office all agreed that the crew could leave the scene. Before the crew could reenter the patient's room, to attempt to get the release signed, the nursing home administrator closed the door to the patient's room and ordered them to leave the premises or be arrested. They left without the release.

The other example offered by the counsel for the General Counsel involved a run that occurred on February 7, 2002. Although there was an attending crew member both crew members received 1-day suspensions and last-chance letters.

Their initial dispatch was to a residence for a "Citizens Assist." This type of call is merely to assist an individual in standing or sitting upright. The individual, who weighed approximately 550 lbs., was lying on the floor and wanted help to get on the couch. Kevin Krause the nonattending crew member called the dispatcher and requested additional backup from either the police or fire department. Two police officers arrived and the four of them accomplished the mission. The EMS crew departed without completing any paperwork.

Before addressing the second dispatch for the same person the issue of whether paperwork is required for a "Citizens Assist" call must be addressed. The written warnings given to each of the crew are identical and are the same as that given to Pina, i.e., failing to complete paperwork or contact medical control. The Respondent, in brief recites the basic facts, including the fact that after the individual was assisted onto the couch the crew left the residence. At a later point in the brief the Respondent, mistakenly, blends the two separate and distinct separate runs, and concludes that the crew "did not simply walk away" but arranged for another vehicle to make the transport (R. Br. at 33) I do not find those statements accurate.

Counsel for the General Counsel's brief not only recognizes the two separate dispatches but also relies on a document entitled "Investigation Krause—Willnow Patient Abandonment" with a computer signature of "Cheryl Russell Operations Supervisor Community EMS" at the bottom of the page (GC Exh. 25). Russell testified that the investigation was conducted by the crew's supervisor, Buell, and that the document reflects Russell's typed notes. Russell also testified that the disciplinary file she provided to the counsel for the General Counsel contained two pages of handwritten notes (GC Exh. 34). She credibly denied knowing who prepared and signed the notes, and she denied using any of that information in her report. Although the notes were admitted over the Respondent's objection, I find them to be without probative value.

Russell's testimony, however, does contains some ambiguity. Thus, in response to a question asking if the report was done at anyone's request, Russell states "No, it was my notes." In response to this followup question: "Your notes, okay. And Jim Buell is the person who gave you the information to prepare these notes? Russell answers "Jim Buell is the one who did the investigation." (Tr. 667.) Later, when asked "where did you get that information [regarding a specific sentence in the report] from to create these notes?" Russell responds "I believe Krause and Willnow. I never spoke to the [other] crew." (Tr. 669.)

The confusion makes it difficult to establish who is asking the questions, and who is the "I" providing the explanations (GC Exh. 25). The section follows:

> When asked why the S and R papers were not done on both of the calls the crew stated,
> Krause 'I was not attending.'
> Willnow 'The fire department signed and released the patient.'

As I explained to the crew –

1. The crew made contact with the patient and for this reason the crew must sign off the patient.
2. The fire department is Bls and the crew cannot turn over care to a fire department with a lower license level.
3. There were 48 minutes between when the crew cleared and the [other] crew arrived to care for the patient.

Is it Buell telling Russell the answers to his questions, and his explanations, or is it Russell speaking to the crew directly. Krause was not the attending on either run, thus his answer is applicable to both runs. Conversely, Willnow's answer can only be responsive to the second run, because fire department personnel were not present at the first run. Similarly, the first explanation is applicable to the first run only if "contact" is taken literally, and "patient" is substituted for "citizen" and used to refer to an individual who receives no medical attention whatsoever but is only assisted in obtaining an upright position.

The two remaining explanations, imply that very serious deviations from the Respondent's policies (the run occurred in Wayne county and counsel for the General Counsel offered no evidence regarding that county's protocols). The last two explanations can only refer to the second run because they mention the fire department, and the alleged 48 minute gap in coverage places the incident well beyond the 5:03 a.m. "Citizens Assist" dispatch and nearer to the second "Difficulty in Breathing" dispatch at 6:41 a.m. with the other crew arriving at the same residence at 7:55 a.m.

Krause, who is no longer employed by the Respondent, testified that he prepared an errata that corrects the Russell report (GC Exh. 25 at 2). From a fair reading of both documents it appears that the crew was again dispatched to same residence at 6:41 a.m. The crew arrived along with fire department personnel. This dispatch was for an individual who was claiming difficulty in breathing. The individual was the same 550 lb. person but now the crew did a patient assessment. The assessment indicated that the patient's vital signs were within normal limits, and the patient was in no distress. The patient nevertheless wanted to go to the hospital to get "checked out." For various logistical reasons the transport could not be accomplished by the crews on the scene. The patient therefore refused transport, signed the fire department's release, and both crews cleared the scene together. It was later that the patient was transported to the hospital by a crew from another company.

I find, based on the weight of the evidence, that it has not been established that the Respondent's policies require a sign and release form after completion of a routine "Citizens Assist" dispatch. The record establishes that a run sheet must be accompanied by a sign and release form. Willnow credibly testified that neither a run sheet nor contact with medical control is required for a "citizens assist" dispatch. Her testimony is supported by the fact that there is no evidence indicating that that a patient assessment was performed on the first run. It follows that because no medical treatment or care was required and no transport was needed or requested, there was nothing to document regarding the first run. Russell's undisputed testimony adds support for this conclusion. She states that at no time did she, or any other manager or supervisor, conclude that patient abandonment occurred. She testified that the crew was reprimanded and suspended for failing to obtain a copy of the release from the fire department. She specifically referred to "this incident," the second dispatch, as the reason for the discipline (Tr. 675). Her testimony is consistent with the Respondent's written policy as announced in April 1989 (R. Exh. 20, CMS Policy and Procedure Manual, Subject: Patient's Refusal of Treatment and /or Transportation). Additional tangential support is found in the

Oakland County protocols. Doctor Vayder's testified that the protocols require a signed release if the patient is refusing transportation or care (Tr. 568).

To the extent that Russell's notes explicitly refer to "both" calls I find that either the notes are inaccurate or the question was wrongly stated. In light of the significant errors contained in the investigation report, such a minor mistake is not unlikely. Moreover, there is no question that the individual was in no distress and had normal vital signs at approximately 6:41 a.m. Absent some form of intervention, it would appear that the individual, although apparently uncomfortable, was in at least as good condition the first time the arrived at 5:a.m. Thus, it is evident that this person's condition as well as all the surrounding circumstances, is strikingly dissimilar to Pavloff's patient. This conclusion is also in accord with Russell's credible testimony that, notwithstanding the title on her notes, patient abandonment was never an issue.

"An essential ingredient of a disparate treatment finding is that other employees in similar circumstances were treated more leniently than the alleged discriminatee was treated." *Thorgren Tool & Molding,* 312 NLRB 628 fn. 4 (1993). In the examples provided by the counsel for the General Counsel all the employees received more lenient treatment then Pavloff but the "essential ingredient" of similar circumstances is obviously lacking. The record establishes that the Respondent has consistently disciplined the nonattending crew member by issuing a one-day suspension and a written warning. In the Pina/Shevin incident it is unclear who was the attending crew member. Regardless, the crew was physically prevented from obtaining a release. Notwithstanding the fact that it was the crew that brought the incident to her attention, Russell explained that they were disciplined not because they failed to obtain a release, but because they failed to document the circumstances that caused them not to obtain the release.

Although the Willnow/Krause incident involved a residence and not an institution, as pointed out by the counsel for the General Counsel, the individual was not in medical distress, did not need medical intervention and was not "abandoned," under any definition. The crew remained on the scene until the patient refused transport and signed a release, albeit a fire department release.

Thus, in none of the examples argued by the counsel for the General Counsel was the patient's competency an issue, in none of the examples was the patient ordered to be transferred to the hospital by his treating Physician Assistant, and in none of the examples was there major discrepancies between the medical findings of the crew and the nursing staff assigned to provide the patient with daily care. Conversely, in every example the crew gave a truthful and reasonable, albeit unsatisfactory, explanation for not having a sign and release form and in no case was there any evidence that the patient's condition and circumstances even approached those of the patient for whom Pavloff was responsible.

In sum I am not persuaded by the General Counsel's argument that Pavloff was treated disparately. For the foregoing reasons, I find that the Respondent rebutted the General Counsel's initial burden with overwhelming evidence that it would have discharged Pavloff in any event. Accordingly, I find that the Respondent did not violate the Act by threatening or terminating Vickie Pavloff and I shall recommend that the complaint be dismissed in its entirety.

CONCLUSIONS OF LAW

1. The Respondent is an employer engaged in engaged in commerce within the meaning of Section 2(2), (6), and (7) of the Act.

2. The Union is a labor organization within the meaning of Section 2 (5) of the Act.

3. The Respondent did not violate the Act as alleged in the complaint.

On these findings of fact and conclusions of law and on the entire record, I issue the following recommended[2]

ORDER

The complaint is dismissed.

Dated, Washington, D.C. April 17, 2006

John T. Clark
Administrative Law Judge

[2] If no exceptions are filed as provided by Sec. 102.46 of the Board's Rules and Regulations, the findings, conclusions, and recommended Order shall, as provided in Sec. 102.48 of the Rules, be adopted by the Board and all objections to them shall be deemed waived for all purposes.